Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
KLUM MEDICAL PA
PO BOX 430
ROWLETT TX 75030

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
DALLAS COUNTY

Carrier's Austin Representative Box
Box Number 44

MFDR Tracking Number
M4-12-3312-01

MFDR Received Date
JULY 9, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated o the Table of disputed Services: "This code was originally billed at the work conditioning rate of $36.00 per hour. Upon receipt of payment, it came to our attention that the work hardening rate of $64.00 an hour should have been charged. We then resubmitted the bill as a reconsideration starting our error. We received an eob stating the original payment was being maintained. We then submitted it as a 'corrected claim' since it was within the 95 filing limit. This corrected claim was then denied as 'a reconsideration requires the same codes, date of service, and amounts as original bill. Please note, the second submission was submitted as a 'corrected claim' and submitted within the 95 day filing limit and should not have been considered a corrected bill and not a reconsideration."

Amount in Dispute: $1,216.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 133.307(c)(1)(A) states a request for medical fee dispute resolution shall be filed no later than one year after the date of service in dispute. The DWC date stamp on the DWC 60 form is July 9, 2012. Therefore in accordance with this rule dates of service July 5, 6, 7 and July 8, 2011 are not eligible for dispute resolution."

Response Submitted by: Argus Services Corp., 811 S. Central Expwy, Ste. 440, Richardson, TX 75080

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 5, 2011 through July 8, 2011	Work Hardening Program	$486.40	$0.00
July 11, 2011 through July 21, 2011	Work Hardening Program	$727.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration for payment of medical bills.
3. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission by the health care provider.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 193A – Original payment decision is being maintained. Upon review, it was determined that this claim was process properly. Rule 133.250(d)(1) requires a recon to include same codes, DOS & dollar amts as original bill.

Issues

1. Did the requestor submit the disputed dates of service timely?
2. Did the requestor submit their corrected bill for reconsideration?
3. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code 133.307(c)(1)(A) states in part that a requestor shall timely file with the Division's MDR section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. A request for medical fee dispute resolution that does not involve issued identified in subparagraph (B) of this paragraph shall be filled no later than one year after the dates of service in dispute. Review of the submitted documentation finds there are no related compensability, extent of injury or liability disputes. Medical Fee Dispute Resolution received the request on July 9, 2012; therefore, dates of service July 5, 2011 through July 8, 2011 were not submitted timely and will not be reviewed.
2. Review of the information submitted by both parties finds that the requestor initially billed the incorrect reimbursement amount for the work hardening program rendered to the injured employee. Upon requesting reconsideration the requestor changed the amount to reflect the maximum allowable reimbursement for work hardening. Per 28 Texas Administrative Code §133.250(d)(1) the request for reconsideration shall reference the original bill and include the same billing codes, date(s) of service and dollar amounts as the original bill. The respondent used denial code 193A.

   In accordance with 28 Texas Administrative Code 133.20(g) health care provides may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier. On September 30, 2011, the requestor faxed a corrected claim to the respondent.

   In accordance with 28 Texas Administrative Code §133.307(c)(A) states that a copy of all medical bills…, as originally submitted to the carrier and a copy of all medical bills submitted to the carrier for reconsideration in accordance with §133.250… (B) states that a copy of each explanation benefits (EOB),… relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB. Review of the documentation received by the requestor did not submit documentation to support that a request for reconsideration was made on the corrected claim.

3. Review of the submitted documentation finds that the requestor is not due additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		May 16, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.